Unearthing the Buried City

The Janet Translation Project

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This document is part of *Unearthing the Buried City: The Janet Translation Project*, a series of AI-assisted English translations of Pierre Janet's works.

In his seminal 1970 book: *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Henri Ellenberger wrote:

> *Thus, Janet's work can be compared to a vast city buried beneath ashes, like Pompeii. The fate of any buried city is uncertain. It may remain buried forever. It may remain concealed while being plundered by marauders. But it may also perhaps be unearthed some day and brought back to life* (p. 409).

This project takes Ellenberger's metaphor seriously — and literally. The goal of this work is to unearth the buried city of Janet's writings and make them accessible to the English-speaking world, where much of his legacy remains obscured or misunderstood.

Pierre Janet was a pioneer of dynamic psychology, psychopathology, hypnosis, and dissociation. His influence on Freud, Jung, and the broader psychotherapeutic tradition is profound, yet the bulk of his original writings remain untranslated or scattered in partial form. These AI-assisted translations aim to fill that gap — provisionally — by making Janet's works readable and searchable in English for the first time.

This is not an academic translation, nor does it claim to replace one. It is a faithful, literal rendering produced with the aid of AI language tools such as Chat GPT and DeepL and lightly edited for clarity. Its purpose is preservation, accessibility, and revival. By bringing these texts to light, I hope to:

- Preserve Janet's contributions in a readable English form
- Spark renewed interest among scholars, clinicians, and students
- Inspire human translators to produce definitive, academically rigorous editions

Fixed Ideas of Hysterical Form[1,2]

By Dr. Pierre Janet
Agrégé of the University, Doctor of Letters,
Director of the Psychology Laboratory at the Salpêtrière.

Gentleman, Professor Raymond has charged me with presenting to you today some psychological notions, which will be useful to you for understanding the accidents of hysterics. I must speak to you about *fixed ideas*, which play a considerable role in the pathogenesis of these accidents, and which must be constantly taken into account when one seeks to direct the treatment of these patients.

This study of fixed ideas in hysteria began, as you know, with Charcot's work on *the traumatic accidents of hysterics*. In his lessons of 1884–1885, he gave a now rightly celebrated analysis of several cases of brachial monoplegia;[3] he showed that, to explain them, all gross lesions of the peripheral nerves, the spinal cord, and the brain had to be ruled out. Only one hypothesis remained possible, the one already suggested by Brodie in 1837, and especially by Russel Reynolds[4] in 1869. "It is probably," said Charcot, "one of those transient modifications of the cells of the cerebral cortex which manifest in the form of a psychological disorder." *These are paralyses that depend on ideas.*

Charcot insisted on the primitive emotion at the moment of the accident, on the reproduction of identical facts through suggestion, on treatment by isolation and on moral influences which modify not the physical state, but the pathological mental state of hysteria. Little by little, with many reservations, he applied the same interpretation to other phenomena, to contractures, to mutisms, to anorexias. Many authors, in France and abroad, and in particular Möbius and Strümpell, adopted this conception of hysterical accidents and even went so far as to declare that "one may consider as hysterical all the morbid modifications of the body that are caused by representations, *durch Vorstellungen*."[5]

It must be acknowledged, however, that despite Charcot's demonstrations, despite the new observations, a doubt persisted in many minds. We see authors such as Oppenheim and Jolly in Germany,[6] Grasset in France,[7] and more recently

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[1] Janet, Pierre. "Les idées fixes de forme hystérique," Conférence faite à la Salpêtrière, le 3 mai 1895, *Presse médicale*, iii (1895), pp. 201-203. Reproduced in *Revue de l'Hypnotisme*, ix, no. 12 (1895), pp. 353-367.
[2] Lecture given at the Salpêtrière, May 3, 1895.
[3] Charcot. — "*Œuvres*," t. III, p. 335, 442.
[4] Russel Reynolds — "Remarks on paralysis and other disorders of motion and sensation dependent on idea," 1869. A work on the same subject by Enn, 1878.
[5] Möbius. — "Ueber den Begriff der Hysterie", *Centralblatt für Nerven-heilkunde*, von D. Erlangen, T. XI, 1888, no. 3.
A. Strümpell. — "Ueber die Entstehung und die Heilung von Krankheiten durch Vorstellungen." Erlangen, nov. 1892.
[6] H. Oppenheim. — "Thatsächliches und hypothetisches über das Wesen der Hysterie." *Nerven-klinik der Charité*, oct. 1889.
Jolly. — "Ueber hysterie beikindern." *Sonder Abdruck aus der Berliner klinische Wochenschrift*, 1892, no. 35.
[7] L. Grasset. — "Leçons sur l'hystéro-traumatisme", 1889.

Bastian in England,[8] who seek to interpret hysterical accidents differently. On the other hand, Charcot himself and his students hesitated to generalize this conception regarding the role of ideas in hysteria and used only very rarely, in speaking of these patients, the more precise term *fixed ideas*, which should characterize their accidents.

This hesitation seems to us easy to explain. For a long time, the phenomenon of fixed ideas has been known, already described by Esquirol under the name *monomania*, then long studied by alienists under the names of *emotional delirium*, *mental vertigo*, *obsessions*, *impulsions*, *phobias*, *epileptoid syndromes* of *degenerates*, etc. It was easy to notice that hysterics did not often present phenomena absolutely similar to those described by the alienists, and one did not find in them the true fixed ideas as they were known. This remark is correct, but must not, in our view, be exaggerated. One must seek whether these fixed ideas are not concealed in our patients by taking on a very particular form; one must seek whether there does not exist *fixed ideas of the hysterical form*.

To this end, I will briefly summarize certain characteristics of the most well-known fixed ideas, to show that hysterics do not present absolutely comparable phenomena and to finally note what modification the fixed idea presents in our patients.

I

To observe fixed ideas in their simplest form, I will briefly recall the case of a patient who recently presented herself at the consultation.

Observation I. — Mme A., a thirty-three-year-old woman from a family predisposed to mental illness (an uncle and an aunt on her father's side died insane), has always been slightly backward in her intellect, although in her youth she did not present any clearly characteristic nervous accidents. She married young and, at the age of twenty-four, was obliged to call upon a neighbor from her street to help care for one of her children; I do not know whether this young man's help or his manner seduced her and irresistibly attracted her when he touched the child, but Mme A. fell into a kind of mad and obsessive love. From then on, for five consecutive years, she was unable to detach her mind from the thought of this man. She was entirely absorbed in this amorous idea in an invincible way. She spent her days continually contemplating his image, for she believed she saw him; the slightest noise in the street made her believe she heard him at the door; she spoke of him all day long, uttering tender words. Finally, she committed eccentric acts in order to try to see him again. Since then, this preoccupation has shifted: Mme A. has a fixed idea that she had intercourse with this man and now spends her nights confessing it to her husband — an idea so absurd that it has nearly completely replaced the amorous idea. Moreover, these ideas, even the latter one, have diminished considerably for some weeks, especially since the patient has been isolated and separated from her husband.

[8] T. Bastian. — "Hysterical paralysis", 1893.

I will not dwell on all the characteristics of this fixed idea, which is not the subject of my present study; I will simply point out that all the images — visual, auditory, etc. — that constitute the notion of a person, of Dr. X., developed completely in the consciousness of Mme A. The fixed idea was quite analogous to a suggestion, it was the complete, automatic development of all the elements of an idea outside the will of the patient.[9] Mme A., while lamenting her state, knew very well that she was constantly thinking about Dr. X. Even today, she tells us that she remembers it perfectly: consciousness and memory are therefore complete.

This patient did not present only this symptom of the *fixed idea*; she had for a long time a very particular state of mind which, in my opinion, allowed for the development of the fixed idea. This state, which was especially characterized by suggestibility, consisted of perceptual disturbances, in curious alterations of memory very close to continuous amnesia, this continual forgetting of recent things,[10] in a considerable diminution of will and attention. These various fundamental symptoms constitute the signs of the mental weakness called *stigmata of psychasthenia*.

Finally, other symptoms may be considered as *subsequent to the fixed idea*, as consequences of this idea; these are, first of all, acts, words, delusions, and also new disturbances of sensation, attention, and memory, which are added on top of the first.

If we were to conduct a complete study of fixed ideas, we would have to study separately the *three groups of symptoms*, carefully distinguish what is a primitive stigma, what is an accidental fixed idea, and what is a consequence of the fixed idea. The same phenomenon — doubt, for example — may, depending on the way it presents itself, be simply a stigma, constitute a fixed idea, or depend on an attention disorder following a fixed idea.[11] These distinctions are, in my opinion, not unimportant. One must also study the phenomenon of fixed ideas in itself and note the varieties it presents — depending on whether the idea is complete and develops to the point of hallucination, or whether it is incomplete and most often reduces to verbal possession; depending on whether the idea is primitive or whether it is secondary and derived from the first, as is the case for example with the amorous idea, depending on whether the idea is accepted by the subject who believes in its external reality or whether it is rejected by the patient who realizes its absurdity, etc. But we cannot go into these questions here, as we have studied them elsewhere and it is enough to recall this: Let us note simply that *in this patient*, the three groups of symptoms — the prior stigmata, the fixed idea, and the consequential accidents — are all three *perfectly distinct and visible*, and that in patients of this kind *the consciousness and the memory of their fixed idea are preserved*.

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[9] Pierre Janet. — "Accidents mentaux des hystériques", 1894, p. 30, 56.

[10] Pierre Janet — "Amnésie continue", *Revue générale des sciences*, 1893, p. 176.

[11] I have already discussed some of these distinctions in several articles: "Étude sur un cas d'aboulie et d'idées fixes", *Revue philosophique*, 1891, I, p. 280 ; "Amnésie continue", *Revue générale des sciences*, 1893, p. 176 ; "Histoire d'une idée fixe", *Revue philosophique*, February 1894, p. 121. In all these works, I insisted on the point that the stigmata, even anesthesia itself, may be an indirect consequence of the existence of a fixed idea. But I do not believe this is always and necessarily the case.

II

Hysterics can sometimes present fixed ideas more or less analogous to the previous ones, fixed ideas that are even very complete, but more often this is not the case. If we consider some of these hysterical accidents that we have trouble explaining, following Charcot's theory of fixed ideas, we see that the phenomena are not exactly the same, at least that the various categories of symptoms no longer appear all three with the same clarity.

Here, to begin, is the case of a rather rare hysterical accident, whose description alone is of clinical interest.

Three years ago, Charcot was preparing a lecture that some of you may have heard, on the topic of vertigo in neurasthenia. We searched at his request, without finding clearly defined examples, for cases of vertigo among hysterics, and Charcot concluded in his lecture that while vertigo is frequent in neurasthenia, it is rare in hysteria. This is why the following case seems worth reporting.

Observation II. — B. is a twenty-one-year-old woman whose history is too long and too complicated for me to recount here; she has already exhibited most of the accidents that hysterics can have — spontaneous somnambulisms, contractures, seizures, prolonged delusions lasting several months with consecutive amnesia, etc. I will insist only on a rather curious new phenomenon that has occurred since the beginning of March. When she walks in the street, she suddenly feels seized by a great vertigo, the ground seems to give way beneath her, she feels thrown forward and must cling to trees or walls to avoid falling; the same vertigo comes over her just as violently when she is seated. This accident occurred, at the beginning of March, several times per day; now it occurs barely more than once per day.

This vertigo is not accompanied by any sensation of noise in the ears, nor by ocular disturbances, nor by nausea. It is both isolated and exaggerated; it constitutes, if I may say so, an absurd accident that is connected to nothing precise. I know the patient, and I know how suggestible she is, how many strange tics and bizarre fixed ideas she has had, and so I am inclined to believe that this, too, is a phenomenon of the same kind. But this patient, when questioned in this regard, affirms that she has no obsessive idea and has never had any vertigo; she does not even understand what we mean when we speak to her of such ideas, and she is convinced that it is a purely physical illness.

This same patient presents another, more banal accident: fears that have tormented her for several years. From time to time, without apparent reason, she starts, shudders, feels suddenly seized by a great fear, but cannot currently explain what frightens her in this way. She looks around on all sides to see what has frightened her and finds nothing.

Observation III. — This other patient, C., aged thirty-one, had remained well until the age of twenty-nine, although she was very nervous and very impressionable. At that time, she successively experienced a series of violent emotions: she saw her father lose part of his fortune, she witnessed the agony of a

close friend dying of phthisis, and finally one day she was nearly run over by a car. As a result of this last incident, she was so shaken and trembling that she could not return home; she had to be taken by carriage, but to everyone's astonishment, she fell asleep in the carriage. She had to be carried out while still asleep, and did not awaken until two hours later, without being able to explain what she had felt. Since then, at every moment, at the slightest emotional shock, she falls asleep for two or three hours — once, after being scolded by her father, she slept an entire three days. During the month of February, just before her admission to the hospital, she was having sleep attacks of variable duration almost daily. While in this sleep, she was calm, her eyes half-closed, with only slight twitching of the eyelids, murmuring barely audible words, and eventually awakening without any memory of what had caused the episode. She is a good example of the conditions that determined the sleep episodes, of the continuous nature of the illness, of her temperament — always very emotional and very sensitive, ready to link her sorrows to past memories and to seek the fixed idea, the obsession, that provokes them. But, like the previous patient, C. is quite incapable of retrieving any memory of what happens during her sleep episodes, and she positively denies having ever had any fixed idea or hallucination.

Observation IV. — This patient is a bit different from the previous ones, but I nonetheless believe she can be compared to them from certain points of view. M. is a sixteen-year-old girl who was affected a few months ago, though the illness is now resolved, with a rather disagreeable enuresis. During her sleep, she urinated almost every night in her bed. Many signs which I will not dwell on here show us that this nocturnal incontinence had very special characteristics. It began at the age of twelve, after M. entered boarding school, which provoked a series of emotional troubles and boredom, and was not accompanied by any disorders that might suggest an organic lesion; finally, it did not exist to any degree during the day. Its very nature led me to compare it with the incontinences described long ago by L.-J. Petit and, more recently, by Dr. Jules Janet, in studies on psychopathic disorders of urination and on urinary incontinences dependent on an idea, on a dream. But we always come up against the same difficulty: M. has been questioned in a hundred ways, she absolutely cannot explain what happens at night when she urinates; she has not the slightest memory of any dream whatsoever.

Observation V. — This last observation seems to me the most important of all and worthy of a closer look. Here are the circumstances under which I came to know this patient, whom I have already mentioned in various works under the name of Maria.[12] Four years ago, I was working at Saint-Antoine in the service of my excellent teacher, M. Hanot. Some police officers brought in one morning a young woman they had found lying unconscious in a ditch. She was still holding in her hand a vial containing at the bottom a nauseating liquid which I later learned was a mixture of vulnerary oil and ether. M. Hanot summoned me and said jokingly that if I wanted to study the psychology of a drunk woman, I had a

[12] Pierre Janet. — "Stigmates mentaux des hystériques", 1893, p. 77, 94, 138, 140.

fine case. I thanked M. Hanot for the gift he was giving me and set about getting to know this new patient. Despite all my efforts, it was impossible to get a word out of her; she slept peacefully and deeply. The next day, to my great surprise, she was still sleeping. It was not until the third day that we were able to slightly bring her out of this peculiar sleep and obtain some answers from her.

The information I gathered about her has since been confirmed by four years of observation and by communications from her parents. Maria belonged to a family that was evidently tainted: a brother was hysterical, a sister insane, the father and grandfather were violent drunkards and alcoholics. Despite appearances, Maria was not like them — she seemed to have neither the vice that affected the rest of her family, nor even the inclination toward alcohol. She had never, in fact, liked alcohol and felt no desire to frequent cabarets or to go out in company. But from time to time, especially at the moment of her episodes, she would feel ill at ease, experience a very particular anguish, and leave alone for the city. She would enter all the cabarets, drink alcohol, vulnerary oil, absinthe. In the pharmacies she would point to the bottle of ether on the pharmacist's shelf, and ask for it to be filled again, which the respectable shopkeepers would now refuse. After a few days of this kind, Maria was again found lying in some ditch and taken to the police station or to the hospital, ashamed and in despair at her latest misadventure. In a word, this patient *mysteriously* was tormented predominantly by the impulse toward alcohol and ether.

But we find ourselves quite at a loss if we question the patient, as I did at Saint-Antoine after her awakening, and ask her to describe the impulse that carried her away. She recounts that she felt ill and anxious while at work, but she declares that at that moment she was not thinking about drinking. She knows nothing further of what happened afterward, and only knows of her time in the cabarets through what others have told her. Police officers came to the hospital to question her about some details of her last episode; but despite her distress and efforts, she was unable to recover any memory. The *amnesia* was absolutely complete — it extended *over the entire period of the episode*, from the initial anxiety to the moment of awakening.

This very interesting patient exhibited many other accidents. I will recall only one curious phenomenon which she called her *fixities* and which seemed analogous to an *ecstatic attack*. Very often, in the midst of an otherwise normal state, she would stop and fix her gaze on an object, then remain absolutely motionless, eyes wide open.[13] One could not bring her out of this ecstasy, and she could be moved without her noticing and without her gaze shifting. She would awaken after a period of time, more or less long, with a few sighs, but without the slightest memory of what had happened. In a word, this woman clearly had impulses and even fixed ideas, but could not describe them, for she had neither consciousness nor memory of them.

If we summarize the preceding observations, we see that in these four patients, we do not find all the groups of symptoms that are ordinarily presented by patients obsessed with fixed ideas. *Of the three groups of symptoms* that we have

[13] Pierre Janet. — "Accidents mentaux des hystériques" p. 163.

identified — the preliminary stigmata, the fixed ideas that are conscious for the subject and retained in memory, and the accidents consequent to the fixed idea — *we can observe only two*, the first and the third. The stigmata that characterize suggestibility and mental weakness are, in all these patients, extremely significant; you even know that in these hysterical patients the disturbances of sensitivity, memory, and will have become much clearer and much more characteristic.

The consequent accidents are also very evident; they are vertigo, fears, sleep episodes, involuntary urination, excesses in drinking, drunkenness, ecstasies, new disturbances of sensitivity and memory, etc. But the intermediate phenomenon — the supposed cause of these accidents, the obsessive and impulsive idea, the emotional dream — where is it? The patients hide nothing, and we have no reason to doubt their sincerity. They affirm that they do not think of anything of the kind and that they do not remember ever having had ideas of that nature in mind.

One therefore understands why many authors have hesitated to explain, along with Charcot, the hysterical accidents by fixed ideas, for it is undeniable that, quite often, these ideas do not manifest in them as clearly as in other insane patients.

III

Must we conclude from these remarks that fixed ideas do not exist in these patients, and seek another explanation for their accidents?

We now know that our consciousness does not grasp all the psychological phenomena that occur within us, and that there are many facts in our mind of which we are unaware. This observation is even more true when it comes to hysterics. You know that there are sensations in their minds of which they are unaware, and I recently presented to you a hemiplegic woman who nevertheless had *subconscious visual sensations* in the half of her retina that appeared to be insensitive.[14] You know that these patients also have *memories without being aware of them*; the amnesia that follows somnambulism and disappears during the next somnambulistic episode is proof of it. Well, hysterics also have ideas of which they are not conscious — true *fixed ideas that remain subconscious*.

To verify their existence, one must look in the same patients for the various manifestations of unconscious phenomena in *dreams*, *attacks*, *somnambulisms*, *automatic writings*, etc. All these studies would show us interesting phenomena; we will focus especially on *somnambulisms*, which are easier to present to you here quickly.

Observation II (continued). — B., in whom we have already noted vertigo and fears, presents a somnambulistic state that is very easy to provoke; it is a reproduction of her formerly frequent natural somnambulisms. In this state, she remembers the attacks, previous somnambulisms, delusions, and in particular certain daydreams that she has at any time during the day, in a state of half-sleep,

[14] Pierre Janet. — "Un cas d'hémianopsie hystérique", *Archives de Neurologie*, May 1895, p. 337.

and which she seems to have forgotten while awake. In this state, she tells us very clearly what has been obsessing her since the month of March.

At that time, she paid a visit to relatives who lived in Neuilly; they strongly reproached her for her behavior and tried to force her to reconcile with her mother. On her return, she dreamed of the reproaches that had just been made to her, of her bad conduct, and in her dream she made a resolution — for she always simplified things greatly — to throw herself into the Seine: she climbed over the railing and jumped into the water. But this imaginary fall triggered a jolt that woke her up. She then felt herself falling forward without knowing why, and experienced that impression of vertigo from which she has since suffered. Since then, this dream has repeated itself several times a day, with the regularity of an obsession, each time bringing the consequent vertigo.

In the same somnambulistic state, she also tells us that her fears are not without cause: “At that moment,” she says, “she sees snakes around her.” It is the memory of an incident from her childhood; she had been frightened by a snake, and, as often happens, she saw its coils again during her hysterical attacks. The attacks have disappeared, but the hallucination of the snake still reappears from time to time; only now it reappears in a subconscious manner, the emotion alone — the fear — being clearly perceived by the subject.

Observation III (continued). — One can, by hypnotizing C..., artificially reproduce her sleep states, and to understand the nature and production of these sleep episodes, it is enough to give her a very simple suggestion, such as to dream very loudly. I once tried to get her used to dreaming out loud; now, she expresses her dream fairly well, at least in part. “My poor soul,” she says, “I must put flowers on her grave… white flowers… they’ll make bouquets for me… I need a little white wooden box… they’ll put it between two chairs, we’ll carry it…” etc. You see the funereal nature of the dream, which repeats — as I have verified for two months — almost always the same. Let us not say that the patient has drowsy spells, but rather that during the sleep episodes there are rich, abundant hallucinations that are always the same, and that these dreams fill her narrow field of consciousness enough to leave no room for any other perception and to persist separately, without leaving any conscious memory.

Observation V (continued). — You remember that we could not recover from Maria the memory of her dipsomaniac impulses, nor the dreams that filled her trances. To understand these peculiar states, we must first trace them back to their origin. Maria, daughter and granddaughter of alcoholics, had a very nervous childhood: at fifteen, following a violent quarrel with her father, she had her first convulsive seizure. It was a *hysterical epileptic attack*, which then occurred very frequently. For about four years, these attacks retained their purely hysterical character: aura, sensation of constriction, convulsions, cries, circular movements, and prolonged sleep afterward — everything was quite simple and regular. When the patient was nineteen years old, a peculiar detail of her seizures was noticed: she interrupted her convulsions to play with a glass she always kept near her bed; upon waking, she had no memory of this little act and was surprised when

someone showed her the glass. However, in the next seizure, she repeated it and entered into the same automatism. A little later, during the same period of seizure, one saw her take a bottle of blackcurrant liqueur she had set aside and begin to drink it. Then, *this period of the attack, in which the patient no longer had convulsions, developed into dipsomania*. And during the following four years, the dipsomaniac seizure presented itself as follows: Maria, weakened and anxious, still feeling the sensation of constriction, would suddenly have a few twitches in her limbs and even at times a few convulsions. But the patient quickly became very calm, eyes fixed, and went out; as best she could, she would go to the cafés, all the while drinking whatever she could find, always ether, and often for several days. Finally, she would fall asleep in a sleep that, as I said earlier, was at first the sleep of drunkenness, and especially of the hysterical sleep analogous to that which followed her first seizures. Once, this sleep lasted eight days. Finally, she awoke with complete amnesia of everything that had followed the aura. This is clearly a *hysterical dipsomania*, at least in its development. Can we not say that it is a fixed idea, developed by a suggestion resulting from the spectacle of her father's drunkenness, during a hysterical somnambulism?

We understand it even better if we question the patient in one of those states so easily reproduced in her. During somnambulism, she recovers, like most hysterics, all the memories of her attack. She remembers the streets she passed through, the way she lost her money at the Place de la Bastille, the cabarets where she drank absinthe, the pharmacists who gave her ether, etc. She remembers especially the ideas that obsessed her; she describes her *imperious need to drink*, the thought that "drinking was good for her, that she would die if she didn't drink," etc. She even remembers that, during her first seizures, she constantly thought of her father, the drunken wine merchant, and that she tried to imitate him. Here is the fixed idea that is expressed and fully explained.

While she is asleep, let us also question her — for it is quite curious — about the thoughts she had during the *crises of ecstasy* that I described to you earlier. She questioned herself — she told us so quite precisely — about the object she had fixed her gaze on, and especially about its construction: "What is that? Is it a spring or a coil? How is it made? Do the workers who make these springs know how they're made?" Or again, she questioned herself about a natural object: "How do trees grow? How do they make themselves green?" You recognize here these formulas — they are classic. It is the *delirium of doubt*, or more precisely the *delirium of interrogation*, the *Grübel-sucht*. But here it presents itself in a very particular manner: it is subconscious; the patient, when awake, has no memory of it and can only recover it in somnambulism. Let us then further emphasize, in this brief summary, the case of a patient who presents *subconscious dipsomania and subconscious delirium of doubt*, and does so in a *clearly hysterical form*.

Observation IV (continued). — I will add only a few words to the observation of nocturnal incontinence, and I present it to you only to show how curiously it manifests in this patient and how dream memory is preserved. I told you that before proceeding, I had not been able to recover the memory of the dreams that usually accompany incontinence. In somnambulism, however — at

least at the start of our inquiries — this patient remembered them in an incomplete way. But I noticed that the patient could not produce automatic writing in the manner of spirit mediums. This patient, who could not write down her dreams, nonetheless provided us with dreams related to her nocturnal incontinence. How curious, that she dreams of urinating, but she does not quite fall into the category of patients described by Jules Janet, who fill their dreams with cathedrals and symbolic emotional content. She dreams, for example, that her little sister is crushed by a passing train, or that chimneys fall on her head — at the most emotional moment of the dream, she urinates. This is not at all a patient with subconscious anxiety; the dream alone, in its emotional intensity, shows us how an apparently purely physical accident like incontinence can be the result of dreams that are absolutely forgotten upon waking — phenomena that are purely subconscious.

All these accidents that I presented to you were therefore indeed determined by ideas, despite the patients' insistence on denying any obsessive idea. Only, these thoughts — which in certain cases had been conscious at the beginning — had gradually ceased to be known to the subject. They no longer manifested except in dreams or in somnambulistic states, and remained below the threshold of consciousness, like sensations in hysterical anesthesia.

IV

Gentlemen, this particular form that fixed ideas take in certain cases does not seem to me to be a mere clinical curiosity. This study is important from many points of view.

(1) This study may be useful for clarifying the classification of mental illnesses. Instead of grouping together all these fixed ideas — these monomanias that thus form a somewhat too confused cluster of diverse symptoms — one can set apart, as a fairly well-defined group, the fixed ideas of hysterical form. No doubt, other subdivisions will still need to be established, but this one highlights an important psychological characteristic.

(2) This study seems to us interesting for theory, for the interpretation of fixed ideas. This dissociation of the mind, which is observed in hysteria — this isolation of the fixed idea outside the control of other psychological phenomena — are important characteristics that allow us to better understand its development and its power. I would not be surprised if, in order to understand fixed ideas in general, one were obliged to begin with the study of subconscious fixed ideas.

(3) Finally, the consideration of this form of fixed ideas is not without importance from a therapeutic point of view. You have noticed that most of the patients I presented to you are recovered patients, for whom the fixed ideas are now nothing more than a memory.

B.'s vertigo still persists because I wanted to show you this patient without having modified her symptoms; from the observations I have already made of these accidents, I know that they disappear very easily when the dreams that

determine them are modified.[15] C., after six weeks of treatment, no longer has spontaneous sleep episodes; her dreams no longer recur except when I recall them in the artificial somnambulism that you saw — that is to say, they have disappeared as a hysterical accident. M., who for four years urinated nearly every night, is not entirely cured, but now only has nocturnal incontinence in a very irregular way, barely once a month.

Finally, allow me to say a few words about Maria's recovery. This woman, who had terrible dipsomania attacks every month for ten years — which at first were long and numerous — has now, for two years, had no further relapse. Instead of drifting through hospitals and prisons, she has taken up a trade, earns an honest living, and has recovered the intelligence and emotions she had entirely lost. Psychology, as you can see, can be quite effective when it succeeds. If these recoveries were possible, it is because it was possible to act upon these fixed ideas, to dissociate them. Just as these accidents resist all therapeutic intervention when they are poorly understood, when their origin is not traced, so too are they easy to make disappear when one has properly grasped their mechanism.

Thus, this study of fixed ideas of the hysterical form has developed fairly quickly.

I presented, a few years ago, the description of a patient of this kind in 1886; I then returned with greater precision to the description of the type in 1889 and 1891, and in a large number of more recent works. I was very pleased to see a student of M. Pitres, Dr. Laurent (from Bordeaux), in an interesting thesis on secondary states (1893), confirm my interpretation and provide other curious observations of similar phenomena. M. Pitres himself, in an article in the *Progrès médical* in 1893, showed dreams that could be produced of which the subject had no memory, and whose notion could only be recovered during hypnosis.

In Germany, the works of M. Pick, of M. Breuer, of M. Freud, have brought new observations, some of which clearly relate to the same facts.

Finally, you are familiar with the very recent and remarkable work of M. Lévy on Raynaud's disease and erythromelalgia in hysterics:[16] this work shows us very clearly how subconscious dreams can determine vasomotor disturbances.

It seems to us that these studies may be presented as a continuation of Charcot's work on illnesses caused by ideas, by imagination, and that they have helped to explain and support the very accurate interpretation he had given of certain hysterical accidents.

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[15] These vertigo episodes completely disappeared after two somnambulistic sessions in which I simply tried to erase the dream of suicide.

[16] L. Lévy. — "D'une forme hystérique de la maladie de Raynaud et de l'érythromélalgie." *Archives de Neurologie*, 1893, p. 102, 166.